

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=63-001907

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 149, Primary Registration District No. 1062, Registrar's No. 196

STATE FILE NUMBER

FILED JAN 28 1963

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

George C. Kealhofer, M.D., Medical Certification

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		c. CITY OR TOWN KANSAS CITY	
Length of stay in 1b 4 YEARS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5323 WOODLAND Avenue		d. STREET ADDRESS (If outside, give location) 5323 WOODLAND AVENUE	
3. NAME OF DECEASED (Type or print) First MARY Middle EMMA Last TRENT		4. DATE OF DEATH JANUARY 9th 1963	
5. SEX FEMALE	6. COLOR OR RACE CAUCASIAN	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1/2/87
9. AGE (last birthday) 76		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	
11. BIRTHPLACE (City and state or country) BELTON, MISSOURI		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME ALBERT SHIRK		13b. MOTHER'S MAIDEN NAME LAURA BELLE CONCANNON	
14. NAME OF HUSBAND or wife JOHN B. TRENT		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) NO NONE	
16. SOCIAL SECURITY NO.		17. INFORMANT KANSAS CITY, MISSOURI ELSIE A. THORPE, 5323 WOODLAND AVE.	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage Due to (b) Hypertensive cardiac disease Due to (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 1-1-63 3:45 A. to 1-8-63 and last saw her alive on 1-8-63 Death occurred at m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) George C. Kealhofer, M.D.		22b. ADDRESS 6625 Prairie St. St. Louis 1-9-63	
22c. DATE SIGNED 1-9-63		23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
23b. DATE JAN. 11, 1963		23c. NAME OF CEMETERY OR CREMATOR MEMORIAL PARK CEMETERY	
23d. LOCATION (City, town, or county) KANSAS CITY		23e. STATE MISSOURI	
24. FUNERAL DIRECTOR D.W. NEWCOMER'S SONS, KANSAS CITY, MO.		25. DATE RECD. BY LOCAL REG. 1-11-63	
26. REGISTRAR'S SIGNATURE Ruth Long			

USE BLACK INK
OR
TYPEWRITER RIBBON

EXHIBIT 3 SERIAL 012317

DR George Heald/Hofer #10
6627 Prospect, Des Moines
12:30-5:00 PM - W O O

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Vern Lawler

Licensed Embalmer No.

4915

P. O. Address

KG mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.